ARIZONA DEPARTMENT OF ECONOMIC SECURITY
DIVISION OF DEVELOPMENTAL DISABILITIES
UNIFORM BILLING DOCUMENT (Short Form)

Bill I.D. Number: _____

3. PROVIDER OF SERVICE AHCCCS ID# (THERAPIES ONLY) _____ PAGE _____ OF _____

1. PROVIDER NAME: _____ 4. MONTH/YEAR OF SERVICE: _____ 6. CONTRACT #: _____

2. FEI / SSN: _____ 5. SERVICE: _____ 7. District: I II III IV V VI VII VIII

8 PROV LOC	9 ASSISTS CLIENT ID	10 CLIENT NAME (LAST)	11 CLIENT NAME (FIRST)	12 SVC START DATE	13 SVC END DATE	14 SVC CODE	15 POS	16 DEL UNITS	17 NO SHOW/ ABSENT UNITS	18 TOTAL UNITS	19 RATE	20 TPL CODE	21 TPL AMT	22 TOTAL	23 SITE RATE COUNT	24 BUDGET SOURCE CODE

25. TOTAL: _____

26. I certify that the information contained in this billing document is true and correct and has been prepared in accordance with the terms of the contract.

_____ PREPARER'S SIGNATURE & DATE

_____ PREPARER'S NAME & TELEPHONE NUMBER

27. $ _____ TOTAL BILLING AMOUNT SUBMITTED UNDER THIS INVOICE

_____ PROVIDER'S SIGNATURE & DATE

_____ PROVIDER'S NAME & TELEPHONE NUMBER

_____ DDD SIGNATURE & DATE PROCESSED

CLAIM #: _____ CLAIM #: _____ CLAIM #: _____